Division of Medicaid **State of Mississippi** **Provider Policy Manual**	**New:** **Revised: X** **Current:**	**Date:** **Date: ~~11/01/05~~** **05/01/07**
Section: Vision	**Section: 29.09**	
Subject: Cataract/Ocular Surgery	**Pages: 1** **Cross Reference: 29.06 Eyeglasses** **52.13 Modifier -54,-55, and -56**	

Coverage Criteria

The Division of Medicaid covers eyeglasses (frames and lenses) for beneficiaries who have had surgery on the eyeball or ocular muscle. The surgical benefit will be applied regardless of whether the beneficiary has received eyeglasses during the benefit period when all of the following criteria are met:

- Surgery results in a vision change, **AND**
- Eyeglasses are medically indicated within six (6) months of the surgery, **AND**
- Eyeglasses are prescribed by an Optometrist or Ophthalmologist.

Beneficiaries who undergo multiple surgeries (Example: cataract surgery) will be eligible for the benefit following each surgery if all criteria is met.

Beneficiaries who experience refractive changes **after** the six (6) month post surgical period are subject to the eyeglass benefit limitations set forth in Section 29.06.

Modifiers

Refer to section 52.13, Surgery of this manual.

Exclusions

The Division of Medicaid does **not** cover refractive surgery including, but not limited to, Lasik surgery, radial keratotomy, photorefractive keratectomy, and astigmatic keratotomy. Beneficiaries who undergo these procedures will **not** receive the surgical benefit described above. Beneficiaries who need eyeglasses following any of these surgeries are subject to the eyeglass benefit limitations set forth in Section 29.06.

Providers must adhere to policies found in other sections of this manual.

~~All professional and institutional providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program and upon request, make these records available to representatives of DOM for substantiation of any or all claims. Documentation supporting the medical necessity of Medicaid claims should be maintained a minimum of five (5) years in compliance with state and federal regulations and laws.~~

~~In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and those paid for by Medicaid, the provider must maintain auditable records that will substantiate the claim submitted to Medicaid. DOM, the UM/QIO, and/or the fiscal agent have the authority to request patient records at any time to conduct a random review and/or documentation of services billed by the provider.~~

General Documentation Requirements

At a minimum, Vision medical record documentation must contain the following on each ~~patient~~ beneficiary:

- Date(s) of service
- Demographic information (Example: name, Medicaid number, date of birth, etc.);
- Current medical history;
- Examination and/or treatment rendered;
- Specific name/type of all diagnostic studies (Example: laboratory, radiology, etc.) and the result/finding of the studies;
- Specific order for all lenses, lens coating, and ocular prosthetics; and
- Provider's signature or initials.

Refer to Section 7.0, General Policy for additional documentation requirements.

Medical Necessity Documentation Requirements

In addition to the general requirements noted above, documentation must support medical necessity based on the criteria in individual coverage sections of this manual.

Lenses/Lens Coating Documentation Requirements

~~In addition to the general requirements, documentation must support medical necessity based on the criteria in individual coverage sections of this manual.~~
In addition to the general requirements and medical necessity requirements noted above, providers must document the following for lenses and lens coating:

- Orders and prescriptions for ~~eyeglasses~~ eyeglass lenses must include lens specifications such as lens type, power, axis, prism, absorptive factor, and impact resistance.

- Orders/prescriptions for contact lenses must include lens specifications such as power, size, curvature, flexibility, and gas permeability.

- Orders and prescriptions for lens coating must include ICD-9 diagnosis and/or narrative diagnosis.

If the provider rendering the service is other than the ordering/referring provider, the provider rendering the service must maintain hard copy documentation of the ordering/referring provider's prescription for a minimum of five (5) years. The prescription must include all specifications noted above.

Lacrimal Punctum Plugs

Refer to Section 29.15 of this manual section.

~~Nonsubstantiated Services~~

~~DOM, the UM/QIO, and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the vision provider. If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.~~

~~A vision provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.~~

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Section: Vision Subject: Reserved For Future Use	Section: 29.14 Pages: 1 Cross Reference:	

Section 29.14 is RESERVED FOR FUTURE USE.

Lacrimal punctum plugs are devices inserted into the lacrimal punctum, an opening in the lacrimal canaliculi located on the upper and lower eyelid margin near the nose, to obstruct tear drainage and thereby preserve the natural tears. Insertion of punctum plugs is considered a surgical procedure and should be considered only for the treatment of moderately severe to severe dry eye syndrome when more conservative treatments, such as artificial tears and adjustment to medications that may contribute to dry eye symptoms, have proven to be ineffective.

There are two (2) types of punctum plugs:

- Temporary (dissolvable) Collagen Plugs

  Collagen plugs are used for diagnostic purposes. If these plugs are inserted on an individual with dry eye syndrome, the individual will experience relief during the period of occlusion. If the individual does not have dry eye syndrome, the individual will experience epiphora (excessive tearing). Collagen plugs usually dissolve within four (4) to ten (10) days of insertion.

- Semi-Permanent Silicone Plugs

  Silicone plugs are non-dissolvable. They are considered semi-permanent because they can fall out or may need to be replaced.

Coverage Criteria

DOM will cover medically necessary insertion of collagen and silicone punctum plugs when there is a documented diagnosis consistent with moderately severe to severe dry eye syndrome. Prior authorization is not required. **A signed treatment/surgical consent form, specific to plug insertion, is required.**

Exclusions

DOM will **not** cover the following:

- Insertion of silicone plugs **less** than ten (10) days following collagen plug insertion
- Insertion of plugs for the treatment of any condition other than dry eye syndrome (example: contact lens intolerance, refractive correction, glaucoma, sinus maladies)
- Repetitive use of temporary (dissolvable collagen) plugs when semi-permanent or permanent treatment is indicated
- Repetitive use of semi-permanent (non-dissolvable silicone) plugs when there is an absence of documentation to support the need (example: plug fell out) and/or when permanent treatment is indicated

- Separate reimbursement for the plug itself (i.e., the cost of the plug is included in payment for the insertion)

Billing

DOM will reimburse for up to two (2) collagen or silicone plugs per office visit. In most cases, placement of one (1) plug in each lower punctum will be sufficient to alleviate symptoms. Up to two (2) additional plugs may be performed for a total of four (4), but documentation must reflect that the additional plugs were medically necessary. There must be a period of not less than ten (10) days between the insertion of collagen plugs and the insertion of silicone plugs.

CPT code 68761 is the correct code for "*closure of the lacrimal punctum; by plug, each.*" The word "each" refers to each plug that is placed in a punctum. Modifiers should be applied as follows:

- E1 – Upper lid, left eye
- E2 – Lower lid, left eye
- E3 - Upper lid, right eye
- E4 - Lower lid, right eye

CPT 68761 does not differentiate between silicone and collagen plugs. The same code is used for either type. Consequently, there may be both a diagnostic (temporary, dissolvable collagen) occlusion of the puncta and a therapeutic (semi-permanent, non-dissolvable silicone) occlusion done on the same beneficiary within a short amount of time. DOM will **not** reimburse if the length of time between insertion of collagen and silicone plugs is less than ten (10) days.

The billing/reimbursement policies for multiple surgery and bilateral procedures policies apply. Refer to Sections 52.03 and 52.04 of this manual.

DOM will not reimburse for an evaluation and management (E&M) CPT code billed with CPT 68761 on the same date of service.

Documentation

In addition to the general documentation and medical necessity requirements found in sections 7.03 and 29.03 of this manual, providers must document the following for insertion of lacrimal punctum plugs:

- Symptoms – dryness, scratchiness, itching, redness, burning, foreign body sensation
- Comorbidities that might be related to ophthalmic disease
- Diagnostic tests and results – visual acuity exam, slit lamp exam, tear film break-up time (BUT), Schirmer's tear test, staining procedures etc.
- Signed treatment/surgical consent form(s) specific to insertion of plug insertion
- Specific treatments rendered, including conservative treatments, and the results.
- Operative report(s)

Documentation must be sufficient to support the type (temporary/semi-permanent) and the number of plugs inserted. Documentation must reflect a minimum of ten (10) days between insertion of temporary plugs and the insertion of semi-permanent plugs.

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Refer to Section 29.0, Vision in this manual.